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ABSTRACT

The report contains the findings and recommendations of an evaluation of the Community Training Home program operated by the Connecticut Department of Mental Retardation. The section on background information provides details of the history of the program which currently provides foster care services for 478 people with mental retardation of which 164 were children and 155 were labeled severely or profoundly retarded. The strengths of the program are identified next and include the program model based on placing retarded persons into typical homes and families. The next section identifies problems and offers recommendations. These include redefining the training home; division into separate programs for adults and for children, with distinct policies for each; adoption of permanency planning as a formal policy for children with an increased subsidized adoption rate; clarification of the authority of the Central office vis-a-vis the regions; development of an annual plan for program operation; development of a single, simplified rate level system for the program; establishment of a standard personal allowance; allocation of additional funds to respite and support services; development of separate training programs for home service providers; improved monitoring of the homes; intensive training for professional staff; development of a statewide quality assurance system; and expansion of the Community Training Home program. (DB)

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AN EVALUATION OF CONNECTICUT'S COMMUNITY TRAINING HOME PROGRAM

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AN EVALUATION OF CONNECTICUT'S COMMUNITY TRAINING HOME PROGRAM

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"We treat the kids like kings and queens. But that's the only way. Children should always get the best. These kids are no different."

"DMR's expectation is to offer all kinds of services for the basic room and board rate."

"Some day I will need help, someone to care for me. . .If I do a good job now, maybe somebody else will do the same for me."

"To see her happy and smiling is like money in my pocket."

"I have continued despite the system. No one else is doing this because the system is so crappy and wide open for abuse because of lack of support, funding, and training."

"The Lord calls you to do things."

"We couldn't have children of our own. This gives us our family."

"It is a fulfillment for me, a way of doing something good."

"I do it with the help of the Lord. That's the best part."

"This is not a business. This is their home. They will stay here as long as they can."

"The kids need reassurance that they won't be dumped, pushed out. They have to know they have a place."

"There are a few bad homes. The good homes need to be looked at and show-cased."

--Connecticut Community Training Home Families

INTRODUCTION

This report contains the findings and recommendations of an evaluation of the Community Training Home program operated by the Connecticut Department of Mental Retardation. The purpose of the evaluation was to identify the program's strengths and weaknesses and to provide recommendations to strengthen administrative, fiscal, programmatic, and philosophical aspects of the program.

The report is divided into four parts: Background Information on Connecticut's Community Training Home Program; the Strengths of the Current Program; Problems and Recommendations; and An Additional Issue. The Appendix describes the Evaluation Methodology.

BACKGROUND INFORMATION

Like other states, Connecticut has established a specialized foster or family care program for people with mental retardation. Administered by the Department of Mental Retardation (DMR), Connecticut's program serves both adults and children in private dwellings licensed to provide residential services. Connecticut's program is referred to as the "Community Training Home" program. In other states, this program is referred to as "host homes," "extended families," "specialized foster care," "adult foster care," "shared homes," "family care," "personal care," and, like Connecticut, "community training homes."

While Connecticut had operated a foster care program for people with mental retardation for a number of years, a "specialized" community training home program was established by the New Haven Regional Center as a pilot project in 1978. Under the pilot project, community training home providers would receive special training and be paid higher rates in return for their services beyond the provision of room and board. In 1981, a state task force called for the implementation of the specialized community training home program throughout the state. According to a DMR document, five of the six current DMR regions were paying community training homes the specialized reimbursement rate as of November, 1985. Although DMR appears to be phasing out "regular" community training homes, both "specialized" and "regular" community training homes may be found throughout the state today.

DMR has established licensure regulations and a reimbursement rate structure for community training homes. The licensure regulations contain minimum standards for the operation of community training homes.

As of February, 1986, 478 people with mental retardation were placed in community training homes; 164 of these were children ages 1 through 20, and 155 were labeled severely or profoundly retarded. The six DMR regions vary widely according to the number and ages of people placed in community training homes. TABLE I contains a breakdown of the number of people placed in community training homes in each of the regions.

TABLE I.

NUMBER OF PEOPLE PLACED IN COMMUNITY TRAINING HOMES

BY REGION

Region	Number of People
1	150
2	41
3	81
4	33
5	108
6	66
Total	478

TABLE II contains a breakdown of the number and percentage of children placed in each region.

TABLE II.

NUMBER AND PERCENTAGE OF CHILDREN IN COMMUNITY TRAINING HOMES

BY REGION

Region	Number of Children	Percentage of Children
1	44	29%
2	8	20%
3	27	33%
4	15	45%
5	61	56%
6	9	14%
Total	164	34%

In recent years, Connecticut's community training home program has received considerable attention from providers, DMR regional staff, and others. Many recommendations have been made for improving the program, especially in regard to the rate structure, central office procedures, and respite. In preparing this report, we have reviewed each of these recommendations.

THE STRENGTHS OF THE COMMUNITY TRAINING HOME PROGRAM

While this evaluation has identified a range of problems with the current community training home program, it would be misleading to suggest that the program is without its strengths. To the contrary, in the course of our evaluation, we identified a number of strengths of the community training home program. In considering changes in the program, it is important to take these strengths into account.

1. The model: typical homes and families. The placement of people with mental retardation into typical homes and families in the community is the hallmark of the community training home program. This "model" enables people with mental retardation to enjoy home life and to live together with typical members of the community. Compared to group homes and other residential programs, the approach offers a high potential for community integration and the development of relationships with nondisabled people. From an economic standpoint, foster care or family placement is more cost-effective than any other residential program.

As a model, foster care, family care, and similar arrangements such as community training homes should play a major role in any state's mental retardation service system. For children, foster homes are clearly the "placement of choice" after natural and adoptive homes. In other words, when children cannot live with their natural or adoptive families, foster care is a preferable alternative to any other out-of-home placement. All children, regardless of severity of disability, need a warm and loving home atmosphere and stable relationships with adults. Some service systems, such as Michigan's Macomb-Oakland Regional Center, have been successful in placing children with severe and multiple disabilities, medical involvements, and challenging behavior in foster families.

Many adults with mental retardation can also benefit from living with a family or sharing a home with a nondisabled person. For adults, the parent-child relationship implied by foster care is inappropriate. Some service systems and agencies, such as Region V Mental Retardation Services in Nebraska and Options in Community Living in Wisconsin, define "family placement" broadly to include roommate relationships between mentally retarded and nondisabled people. Of course, many adults with mental retardation are capable of living independently or with occasional support.

In short, as a model or basic approach, the community training home program is a sound one and one that should be expanded.

2. The Families or Providers. The greatest strength of DMR's community training home program lies in the commitment of the families who have taken people into their homes. In speaking with community training home families or providers and visiting their homes, we have been impressed and, in many cases, deeply moved by their caring and concern. As one DMR regional official described them, they are ordinary people, but extraordinary in many ways.

Community training home families, or providers, became involved with the program for a number of reasons. Many--in fact, the majority of families we interviewed, expressed religious reasons for taking people with mental retardation into their homes. Several mentioned a "calling." Some families sought out children because they couldn't have children of their own. A couple people have backgrounds in nursing or special education and take professional pride in caring for children with severe medical involvements or challenging behaviors. Still others, especially older providers, like the companionship they receive from the people placed in their homes. For more than a few families, money served as an inducement for becoming a community training home. But it would be unfair to say that families are "in it just for the money." Except for a very small handful, this would not be true.

In conducting the evaluation, we came across some excellent examples of what community living should mean. Many families regard the people placed in their homes as full family members. They involve them in their own social networks and include them in church, vacations, and social outings. At least seven families (out

of 10 having children placed in their homes) have explored the possibility of adoption. Some of the people having adults placed in their home have developed a strong relationship with them. One older woman is a provider for three women she refers to as the "ladies"; they range in age from the late 60's to early 80's. The four women seem to enjoy each other's company and go everywhere together. In nice weather, they spend a lot of time at the beach and all have noticeable sun tans in very early spring.

We also came across same bad examples, though not many. While we did not find any evidence of abuse, neglect, or dangerous situations in any of the homes, not all of placements were ideal. This did not seem to be because the families, or providers, were malicious or uncaring. One home did not meet acceptable standards of cleanliness (to put it another way, it was filthy). Even in this case, the person placed in the home had been offered another place to live and had declined to leave. Some families seemed overly protective of the people living in their home and stifled their independence and regarded adults as children. One family expressed negative attitudes about one child's ability to appreciate a family atmosphere, although this family also described itself as "burnt out."

These families are not perfect, but they are good people. If there is any overriding conclusion from this evaluation, it is this: respect these families, support them, and treat them as valuable resources, because they are.

3. The DMR Mission Statement. In February, 1986, the Connecticut Department of Mental Retardation adopted a Mission Statement that sets forth what it stands for. The Mission Statement reads:

> The mission of the Department of Mental Retardation is to join with others to create the conditions under which all people with mental retardation experience:
>
> . Presence and participation in Connecticut town life.
>
> . Opportunities to develop and exercise competence.
>
> . Opportunities to make choices in the pursuit of a personal future.
>
> . Good relationships with family members and friends.
>
> . Respect and dignity

With regard to the community training home program, DMR's Mission Statement provides definition, guidance, and direction.

4. Commitment within DMR Regions. This evaluation identified many problems with DMR's community training home program, as described later in this report. However, in pointing out the

problems with the current program, it would be unfair and ill-advised to overlook the exemplary efforts of many DMR regional staff. Scattered throughout the regions are competent and committed case managers, administrators, and professionals.

Several examples stand out.

*A case manager in one region spoke with respect about both families and the people placed in their homes. Describing her clients, she said, "They are all very different from each other. They have the same needs that we do, for community involvement, for education, and work." She explained why it is important to get to know each client as a person and commented that she goes to lunch with someone almost every day. She also talked at length about the need to keep in touch with natural families: "This is really important for me and I spend a lot of time on it. I send a letter once a year with pictures of the person."

*A nurse assigned to the community training home program in another region works hard to meet her client's health-related needs. As in many communities around the country, she has problems finding doctors and dentists who will accept Medicaid-funded patients in her region. She has been going through the

yellow pages of the phone book calling every dentist in the area. She has called every dentist up through "M" and has found three who will accept her clients. She also has to fight to get her clients adaptive equipment: "You have to make out that the person will just about die if they don't get a piece of equipment or therapy. . .I get the money from Title XIX and anywhere else I can squeeze it out of."

*In one region, administrators try to come up with front money for community training homes waiting three to six months or more to receive their first reimbursement from the state. The region gets the money from anywhere it can. Sometimes staff members donate money.

*An administrator in the same region stresses the importance of careful planning in placing people in community training homes: "We are not quick and throw people in. We move slowly, carefully. We give providers a lot of support and meet with them regularly. We never have many alternate placements out of here. People stay placed. Community training homes enable people to form caring relationships with others, often for the first time ever. Our office does not have the emergency quality in service delivery. We plan for people."

*A behavioral specialist assigned to the community training home program in one region emphasizes positive, nonaversive behavioral management approaches. She spent a lot of time working with a school that one of her clients attended to halt the use of aversive procedures.

In looking to strengthen the community training home program, DMR should build on the current efforts of many regional administrators and professionals who have come up with creative ways of supporting people in community training homes.

5. Increased resources devoted to the community training home program. DMR has begun to allocate additional staff and resources to the community training home program. In its most recent budget, DMR requested additional professional and case management positions to recruit, train, and support community training homes. In addition, DMR has allocated funds for respite that can be used to support community training homes as well as natural families.

PROBLEMS AND RECOMMENDATIONS

This section of the report describes the major problems with DMR's community training home program identified through the evaluation. For each problem, we also present recommendations to strengthen the program.

Definition of the Community Training Home Program

Problem 1. The community training home program suffers from a lack of definition and clarity regarding its purpose.

The community training home program has never been clearly defined or conceptualized. As a result, regional staff members hold different expectations for the program and providers do not receive sufficient guidance regarding their role.

In the course of our evaluation, one key question arose again and again: what is the major purpose of this program? The name suggests that the major purpose is to provide training. Yet this presents a misleading picture of these homes today.

Community training home providers, or families, do not receive the support or training to be teachers or trainers. As we discuss in a later section, regional training programs range from nonexistent to inadequate. Some regions do not offer any training and even in those regions where initial training is provided, this does not sufficiently prepare providers to offer training. No region sponsors mandatory inservice training for community training homes.

Most providers, or families, do not view their role in terms of providing training or habilitation. While a small number of providers regard themselves as professionals, most see themselves as offering room and board, supervision, companionship, and a home

atmosphere. Many families with children placed in their homes view themselves as parents and have developed deep emotional attachments to the children in their homes.

DMR regional staff do not share a common understanding of the purpose of the community training home program. When asked about the strengths of the program, most regional staff pointed to community involvement, a home atmosphere, and a normalized life style. One social worker explained that the responsibilities of the community training home provider is "to provide a good home environment and to introduce the person to the community."

However, regional staff disagree on other expectations for community training homes. Some believe that community training homes do not provide enough training. One regional staff member commented that most providers only teach people the skills they need to fit into the home and stop there. A social worker complained that community training homes do not prepare people to move on to other placements: "We are not moving people out of community training homes fast enough into group homes. . .If we don't move people fast enough they become attached and won't give them up."

The ambiguity surrounding the purpose of the community training home program creates many problems. First of all, DMR regions lack guidance regarding expectations for community training homes. As a result, the community training home program varies markedly from region to region and often from regional staff member to staff member.

Second, community training home providers, or families, receive mixed messages regarding their role. They are referred to as "operators," "providers," "families," and "parents." On the one hand, they are asked to provide a warm home atmosphere and often to act in a surrogate parent role. On the other, they are expected to function as professional caregivers and trainers. Licensed as community training homes, many providers focus on obtaining better worker benefits. If they are community training homes, suggested one provider, why shouldn't they be compensated like group home and institutional staff? Some want more money (as one regional administrator remarked, the community training home rate is a "low hourly wage"). Others advocate for "more time off" and "better vacations."

Finally, the phrase "community training homes" over-emphasizes training to the exclusion of other important aspects of life in the community. Today, most community training homes are not oriented to formal training. Nor should they be. To be sure, community training homes should provide people with mental retardation support and assistance in learning new skills. Yet these homes can also offer opportunities to become part of the community and to form close relationships with other people. Some homes are doing this. One provider told the story of how a man placed in her home did not speak when he first moved there. She helped him to become involved in a local "Polish Falcons" organization in the community. As it turned out, he happened to be Polish and started using Polish words

at the organization. He now can say a number of words in both English and Polish and has come to be accepted at the organization. Providers should be encouraged to help people with mental retardation to be involved with community life.

Recommendation 1A: By formal policy, DMR should redefine the community training home program in accord with its Mission Statement: To create the conditions under which people with mental retardation experience community presence and participation, opportunities to develop and exercise competence, opportunities to make choices, good relationships, and be accorded respect and dignity.

By redefining the program, DMR would set clear and realistic expectations for community training homes: to help people with mental retardation to be integrated into community life, to give them opportunities to learn new skills ("training"), to provide opportunities to make choices about their lives, to form relationships with others, and to live with dignity and respect. The role of the provider is not simply to be a trainer, but, as a community member, to assist people with mental retardation to lead a typical life in the community.

The definition of the community training home program is not a trivial matter or minor concern. To the contrary, all aspects of the program should flow from how the program is defined.

In addition to redefining the program in accord with DMR's Mission Statement, we believe that DMR should give serious consideration to separating the current program into two distinct programs, as described below.

Children and Adults

Problem 2. The community training home program confuses the needs of children and adults.

The community training home program is a single program that serves both children and adults.

As with other aspects of the community training home program, the regions vary widely according to the number and percentage of children placed in community training homes, ranging from 14% to 56%. Some regional staff members view the program primarily in terms of children; others view it in terms of both children and adults.

No sharp distinction is made between the needs of children and adults in the community training home program. First of all, many homes have both children and adults, sometimes of grossly different ages. For example, one community training home had a 44-year-old, a 17-year-old, and a 10-year-old. Second, training programs for providers do not distinguish between adults and children. Often the training creates inappropriate expectations for the provider's

relationship with adults. One region's training program referred to the "Foster Parent relation with natural parents" and "Introduction to CTH parent." Another region's included passages like: "The difficulty with becoming a Community Training Home parent for the first time is never knowing what to expect" and "Many providers easily establish relationships with their 'foster child' which often leads to adoption." A community training home manual used by another region contained numerous articles directed at foster families for children: "The Foster Child," "Helping Children Cope with Separation and Loss," "Coping with Behavior Problems: Helping Children Develop a Sense of Responsibility," and a series on "Our Foster Child's Natural Parents." Third, people licensed to operate community training homes are often referred to as "parents," whether or not they have children in their homes. In short, providers for both adults and children are related to in the same way.

Neither children nor adults are well-served under the current community training home program. For children, the community training home program is not oriented toward what is called "permanency planning," each child's right to a permanent home and lasting relationships with adults. As discussed in the next section, families may actually be discouraged from adopting children. For adults, community training homes are often overprotective. As one case manager commented, "Sometimes adults are treated as children." In one phone interview, a provider with a severely retarded man in his 60's explained that he sits in a chair

all day with a doll, a truck, or a stuffed animal (she also mentioned that he goes to the regional center one day a week for a "grandmother program").

Recommendation 2A: DMR should divide the Community Training Home program into two separate programs, one for adults and one for children, and establish separate policies for both.

For children, the program should be oriented toward permanency planning. "Providers" should function as extended families and parent surrogates on a temporary or long-term basis and should be provided with information and training on permanency planning, adoption options, relations with natural families, and educational rights. For adults, the program should be defined in terms of a shared home rather than a parent-to-child relationship. Providers should be trained and supported to assist people to participate as fully and independently as possible in community life. Of course, both programs should be guided by DMR's Mission Statement.

Permanency Planning and Adoption

Problem 3. The Community Training Home Program discourages permanency and adoption for children.

The Community Training Home Program is marked by barriers to fulfilling children's rights to a permanent home and family.

In conducting this evaluation, we were struck by the number of families who are open to adopting children placed in their homes, but have been discouraged from doing so. Out of 19 families interviewed, ten were community training home providers for children. Seven of these families have actually considered adopting the children in their home. Each family reported that they have encountered various roadblocks to adoption. Some continue to pursue adoption; others never pursued the idea or have given up.

*One family has three children, including two with severe disabilities, living in their home. They are in the process of adopting the youngest child. One of the family's biggest complaints with the community training home program is that they can only have three children placed in their home, even though they are adopting one of them. They would like to see more flexibility in the program to enable families like themselves to have more than three children when in the process of adoption. They have also considered adopting the other two children, but will not do so if the children must be "put up."

*A woman has a 12-year-old child placed in her home who has lived there since she was one. The rights of the child's natural parents have been terminated. The woman has considered adoption and even filed papers to initiate the process. However, she reported that the Department of Mental

Retardation and Department of Children and Youth Services talked her out of adoption. As she explains, they told her that she would be totally responsible financially and would receive no assistance. Her DMR social worker confirmed that he advised her not to adopt because she would lose financial support.

*A family with two children with severe disabilities were interested in adoption. However, they were told by a worker from the Department of Children and Youth Services that if the rights of the children's parents were terminated, the children would be "put up on the block" and they might lose them.

*A family with three children with severe multiple disabilities and medical involvements would like to adopt at least two of the children. They would even welcome an "open adoption" arrangement with the natural families. According to the family, "DMR never asks parents whether they want to terminate. One of our children's parents haven't seen her in four years."

*An older man, whose wife died several years ago, is a community training home provider for a 15-year-old boy. The boy was placed in the home when he was an infant. The man said that he has considered adoption, but dropped the idea:

"Too many expenses, no extra help with expenses. No, it's not possible to afford."

*A family has three children placed through the community training home program in addition to two adopted children with disabilities. The family plans to adopt more children. They would like to have more children placed in their home through the community training home program while they are in the process of adopting one of the current children. They are express concern about the adoption process. They stated that the Department of Children and Youth Services will photolist the children and if a "more suited family" came along, they would lose them. They also indicated that one of the children's parents would like the family to adopt him and that this would be an "open adoption."

*A family with two children with challenging needs has thought about adoption, but has a number of concerns about it. They said that they are afraid that one child's mother might not go along with it. They also expressed a fear of "uncertainty in the case of emergency" and indicated that the expenses might be hard to bear: "Parents don't get support with adoption." They added that they would need the "support of the agency" to pursue adoption.

Based on these reports from families, several conclusions can be reached. First of all, families do not always receive accurate information. While some of these families were under the impression that they would lose all reimbursement if they adopted children, Connecticut has a subsidized adoption program under which they would qualify. However, as discussed below, the subsidized adoption rate is significantly lower than what families currently receive. It should also be noted that DMR social workers do not always have accurate information about adoption. Of all of the DMR social workers with whom we spoke, not one had correct information on the subsidized adoption program. Second, according to families, social workers are not especially supportive of families interested in adoption. In fact, in some instances they have talked families out of adopting children. Finally, state policies and procedures discourage the adoption of children in community training homes.

Like many states, Connecticut operates separate foster care systems for different types of children. The Department of Children and Youth Services (DCYS) licenses foster homes for "abused, neglected, abandoned, and delinquent" children, while DMR licenses community training home for children with mental retardation. Each department has its own reimbursement structure. DCYS rates, which are based on the age of the child and the level of supervision and support required, are typically lower than DMR community training home rates.

As mandated by the federal Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272), DCYS must periodically review the status of all children in foster care with a view towards obtaining a permanent home for each, whether through family reunification, adoption, or permanent foster care. Each foster child's case must be reviewed every six months as long as that child is in foster care. Since DMR does not receive funds under P.L. 96-272, it presumably is not required to adhere to the requirements of this law.

Since DMR is not licensed to place a child in adoption, DCYS handles all adoptions for children in community training homes. As far as can be determined, adoption is initiated by community training home families. With matching funds under Title IV-E of P.L. 96-272, DCYS sponsors a subsidized adoption program. According to one DCYS administrator, the subsidized adoption rate is <u>75% of the DCYS foster care rate</u> (and not the DMR rate as believed by some DMR regional staff), paid through DCYS' budget. Thus, for DMR community training home families, adoption means a significantly reduced reimbursement rate.

As noted above, some community training home families are afraid that children in their homes will be taken away by other families if they are "put up" for adoption. According to the DCYS administrator, all children legally eligible for adoption are listed on a statewide registration system. The Connecticut Adoption Resource Exchange can also prepare a photolisting of eligible

children for national circulation. The DCYS administrator stated that the chances of a community training home family losing a child to another family would be extremely low in view of the family's relationship with the child. However, the administrator admitted that there had been some widely publicized instances of infants in foster homes in which the foster parents lost the infants to adoptive families.

Recommendation 3A: DMR should adopt Permanency Planning as a formal policy for children in community training homes and should develop policies and procedures to guide DMR regions.

Permanency Planning is a philosophy and practice directed at insuring each child's right to a permanent home and a stable relationships with adults. Permanency planning starts with supports to the natural family. When a child is placed in foster care or any other out-of-home placement, this is viewed as a temporary arrangement and specific plans are made to reunite the family. If family reunification is not possible, then other options are pursued: adoption, shared care (whereby the natural and foster family share responsibility for raising the child), open adoption (in which the natural family maintains a relationship with the child), and permanent foster care (for children who cannot be freed for adoption). Permanency planning requires periodic review of the status of each child.

In developing policies and procedures on permanency planning, DMR should review DCYS procedures and request DCYS consultation and assistance. DMR should also review the Permanency Planning Project operated by the Michigan Department of Mental Health for children with developmental disabilities.

Michigan defines permanency planning as follows:

Permanency planning is. . .

A planning process undertaken by public and private agencies on behalf of developmentally disabled children and their families with the explicit goal of securing a permanent living arrangement that enhances a child's growth and development.

Permanency Planning for children is directed toward securing:

1) a consistent, nurturing environment;
2) an enduring, positive adult relationshp; and
3) a specific person who will be an advocate for the child until adulthood.

Underlying assumptions:

1) It is generally in the best interest of children to remain at home with their family. Therefore, public agencies

should first attempt to plan, provide and coordinate services in such a manner that the integrity of the family unit may be maintained.

2) If a child cannot be maintained at home, it is assumed that a public agency should then give priority attention to the provision and coordination of those services that will facilitate reunification of the child with his/her family at the earliest possible time after placement out of the natural home.

3) If reunification of the child with his/her family is not possible, and there is no active parental involvement with the child, the feasibility of adoption planning should be rigorously pursued.

4) For some children, already in care, strengthening the ties with the birth family by increasing the quality of involvement while the child remains in foster care may be the most appropriate permanency planning option. For certain other children, the permanency planning path may include such alternatives as long-term foster care, supplemented by securing an advocate or guardian.

5) Institutionalization is not considered to be an appropriate permanency planning option.

In addition to developing policies and procedures, DMR should insure that case managers and other appropriate regional staff receive information and training on permanency planning, subsidized adoption, and relations with natural families.

Recommendation 3B: The subsidized adoption rate should be set at 100% of the rate of reimbursement currently received by families.

While recognizing that it may not be within DMR's authority to set the subsidized adoption rate, the current subsidized adoption rate of 75% of the DCYS rate serves as a disincentive to community training home families to adopt children placed in their homes. Community training homes should continue to receive the same rate of reimbursement after adoption.

We understand that legislation to revise the subsidized adoption rate to 100% passed this year and will be effective April 1987. We recommend that DMR provide guidance to the legislature regarding the need to set the subsidized adoption rate at 100% of the family's current (community training home) rate.

Our understanding is that DCYS pays the entire subsidized adoption rate from state and federal funds. We would advise DMR to consider subsidizing through its own budget any funds for subsidized adoption for community training homes beyond the DCYS maximum.

Recommendation 3C: DMR should ensure that all community training home families with children receive adoption services through DCYS or through a DMR contract with a private adoption agency.

Community training home families considering adoption require accurate information, support, and practical assistance. Based on our evaluation, we do not believe that most families are receiving any of this today. While we are not prepared to recommend that DMR attempt to become licensed for adoption services, we do recommend that DMR insure that these services are provided.

Recommendation 3D: DMR and DCYS should continue to collaborate on issues related to the adoption of children with mental retardation.

DCYS and DMR, together with other organizations, have begun to cooperate on issues related to the adoption of children with developmental disabilities. Specifically, DMR and DCYS have cooperated in the planning of a federally funded project operated by DCYS to train and support existing adoptive families of children with special needs.

We recommend that this collaboration be expanded to address other adoption issues. On issues of central importance, DMR and DCYS should be represented by officials at the highest department levels.

Recommendation 3E: DMR regional officials should officially request waivers to permit community training home families in the process of adopting one or more children to exceed their licensed maximum of three persons and the Commissioner, with due consideration of the special circumstances, should act quickly on these requests.

There are community training home families, well-known in their regions, who have three children placed in their home through the program and are in the process of adopting one or more of them. These families would like to have additional children placed in their home while they are awaiting the adoptions to be finalized.

In regard to these families, several regional administrators and staff have suggested that the maximum number of persons placed in a community training home be set at a number higher than three. As a matter of policy, we cannot endorse this suggestion. However, we believe that these particular families, in view of their extraordinary commitment and capabilities, may warrant an exception to DMR regulations.

Since DMR regulations governing the community training home program (Sec. 19a-467-4(c)) gives the Commissioner the authority to grant a waiver of specific regulations, we recommend that DMR regional offices request the granting of waivers in cases deemed appropriate.

Central Office Versus Regional Authority

Problem 4. The authority of the DMR Central Office vis-a-vis the regions regarding the Community Training Home program is unclear.

According to regional administrators and staff, the community training home program has always been characterized by a lack of statewide (Central Office) leadership. As one regional administrator familiar with the program statewide explained, the Community Training Home program is "the ugly stepchild of state programs."

Since the establishment of the community training home program, the DMR Central Office has never provided clear guidance to the regions on the operation of the program. Except for licensing procedures and standards and the rate reimbursement system, the community training home program varies dramatically from region to region (and since the regions were recently collapsed from 12 to six, sometimes within current regions as well). Some regions have had standardized training programs; other have offered no training. Some have paid for respite for providers; others have expected providers to pay for their own respite. Some have viewed the program in terms of children; others in terms of adults. One region has made a number of interracial placements, while an adjacent one does not regard this as appropriate. The regions may also vary in their interpretation of state licensing regulations and the rate reimbursement system.

Most regional administrators and staff express frustration with Central Office. One regional administrator stated, "The people in Central Office don't know the nuts and bolts of the community training home program. Either they don't give us answers or they give us contradictory answers. Central Office is out of touch." Another regional staff member echoed this sentiment: "We used to have regional coordinators meetings but they were disbanded. There was no leadership and we always got into snits. Either the answers were not given or we always had to wait for answers." A third reported, "No one responds to memos."

While the Central Office has not provided the regions with clear guidelines, neither has it granted the regions the authority to make their own decisions. Regional administrators do not seem to know which decisions they can and cannot make. A couple of administrators reported that they try to avoid Central Office and make their own decisions, whether or not they have the authority to do so. Others seem reluctant to make any decisions and wait for Central Office to answer their questions. One regional administrator stated that she dropped the idea of requiring mandatory inservice training for providers when she was informed by Central Office that this was not addressed in the regulations (in point of fact, the regulations explicitly require participation in inservice training as a condition of relicensing). Some regional administrators reported that they do not know where to go in Central Office to have their questions answered.

Recommendation 4A: DMR should clarify the authority of Central office vis-a-vis the regions by developing clear policies to guide the Community Training Home program.

DMR should develop clear policies to provide the regions with guidance on the operation of the community training home program. These policies should be based on DMR's Mission Statement and should address the development of individual plans (the "Overall Plan of Care"), training of providers, financial reimbursement to providers, respite and supports, permanency planning and adoption, monitoring, and quality assurance.

Consistent with DMR's movement toward greater regional authority, the policies should be designed to provide regions with the maximum flexibility necessary to operate the community training home program. Thus, the policies should be viewed as broad mandates, rather than as operational steps. The regions should have the authority to make decisions on any matters not related to the regulations, policies, and DMR Mission Statement.

Recommendation 4B: DMR should require the regions to develop and, upon Central Office approval, implement an annual plan for the operation of the Community Training Home program.

In order to insure the consistency of regional community training home programs with the DMR Mission Statement, regulations, and policies, DMR should reguire the regions to submit to the Central Office written plans for the community training home

program. These plans should contain basic regional information and should include specific plans for the development of individual plans consistent with DMR's Mission Statement, permanency planning and adoption, monitoring, respite and supports, training, and quality assurance. The Central Office should complete its review in a timely manner and confine the review to consistency with the DMR Mission Statement, regulations, and policies.

In the course of this evaluation, many individuals, including several DMR regional administrators and staff, suggested that the Central Office should designate a coordinator for the community training home program. While the assignment of a Central Office coordinator would represent an improvement over the current situation, we believe that this would be premature. We believe that the two recommendations described in this section, the development of policies and the requirement for regional plans, will clarify the authority of Central Office relative to the regions and will provide guidance to the regions and insure statewide accountability, while granting regions the flexibility to develop innovative and responsive community training home programs. The assignment of a Central Office coordinator would only be necessary if the relative authority of Central Office and the regions remains unclear or if Central Office maintains direct control over the Community Training Home program.

Fiscal Issues

Problem 5. The funding of community training homes is cumbersome, complicated, and inequitable.

The funding of community training homes is characterized by numerous problems. As one DMR regional administrator commented, community training home funding causes "nightmares."

It is difficult to obtain reliable information about how community training homes are funded. In the course of this evaluation, we received conflicting reports from Central Office and regional DMR staff and Department of Income Maintenance (DIM) staff. No one within DMR or DIM seems to have an understanding of all of the fiscal issues surrounding the community training home program.

First of all, the rate reimbursement system for community training homes is extremely complex. In fact, it is misleading to refer to the rate reimbursement system, since there are several systems in place. There are currently three rate schedules that apply to community training homes. One is for children and adults who are not covered by Aid to the Disabled (AD) and who are in "regular" community training homes (in "regular" homes, providers have not received training, although this is also true of some "specialized" homes). Under this schedule, DMR pays the difference between the listed rate and unearned income (minus the personal allowance) received by the person (e.g., SSI). According to several DMR

administrators, the "regular" community training home program is being phased out. A second rate schedule is for people who are not covered by AD and who are placed in specialized" community training homes. This schedule includes higher rates for providers. The third rate schedule applies to people 18 years of age or older who are eligible for AD through DIM. Under this schedule, DMR supplements a monthly DIM payment of $589.49 (including $565.14 for room and board, $13.20 for clothing, $8.65 for personal items, and $2.50 for laundry) for "specialized" community training homes. The DMR supplement depends on the client's "level of care." DIM's AD payment is determined by the person's total earned and unearned income, although DIM allows a $100.20 personal allowance "disregard" for unearned income (e.g., SSI)and about a $50.00 disregard for earned income. According to one DMR Central Office administrator, the DMR unearned income personal allowance "disregard" is $25. While DMR funds are paid directly to the provider, AD is paid to the client or his/her representative payee.

All DMR rates are based on "levels of care." For "regular" and "specialized" community training homes for people not covered by AD, the rate structures are broken down by age (for "regular": 0-3, 4-5, 6-11, and 12 & over; for "specialized": 0-9, 10-14, and 15 & Up) and five levels. For "specialized" homes for people covered by AD, there are three rates for levels 3, 4, and 5. The level of care, in turn, is determined by a point system based on six categories of needs. The

points are assigned by social workers or, in some cases, a team, according to are assinged by social workers or, in some cases, a team, according to standard guidlines. Notwithstanding this complex rate reimbursement system, Central Office can grant an exception to the DMR rate upon written request. According to one regional administrator, "Some providers do get $900 per month, but you have to fight for that. Anything extra must be fought for."

The complicated nature of the rate reimbursement system creates problems for regional staff, providers, and clients alike. For regional staff members, the system results in unnecessary paperwork and calculations to arrive at the correct rate and to determine the amount of DMR funds required. As explained by one regional administrator in a memo, the time devoted to financial issues prevents social workers from spending "more time in direct service to the providers and the DMR clients we are trying to serve."

For providers, the rate system causes confusion and inequities. Due to multiple funding sources, some providers must keep track of three separate checks per month.

Because of the separate rate schedules and exceptions, the amount of money paid to providers varies dramatically. One document taken from a DMR computer indicates the "gross monthly amount" for "DMR funded rates" ranges from $0.00 to $1,560, with 50 separate rates for 262 people. Some regional staff members and providers reported that the rates for comparable clients within a single home are often different.

According to some regional staff members, the current system creates inequities for families with children. The current rate schedules are based on a direct relationship between age and funding, when more money is received for adults.

For people placed in community training homes, the rate system appears to be inadequate and, in many cases, inequitable in terms of the personal allowance and other living expenses. However, it should be noted that we received conflicting information on the amount of money available to individuals. According to several DMR and DIM administrators, DIM has a higher personal allowance disregard than DMR. As it was explained, DIM disregarded over $100, while DMR disregarded only $25. In other words, people received a significantly higher personal allowance if they were funded by DIM through AD. This means that children receive a much lower personal allowance than many adults. Some regional staff members also stated that the personal allowance varies from region to region. We were also informed that DMR(upon approval) provides a clothing allowance up to $75 twice a year, although many regional staff members and providers are apparently unaware of this.

It is important to point out that most providers seem to be satisfied with their current rate of reimbursement. Out of the 19 providers interviewed, only two expressed strong dissatisfaction with their rates. At the same time, though, almost all providers believe that the people placed in their homes do not receive enough money for

clothing and personal expenses. As a result, according to the providers, they pay for things for people out of their own funds. One provided explained, "The money is not sufficient to cover your expenses, but you feel committed to the person so you spend the money." Another said, "Nothing is sufficiently funded. Everything must be spent for him and nothing is covered. You have to do it on your own." A third commented, "The ladies don't get very much at all. They deserve more. They have done without for so long." And so on, and so on. Provider after provider decried the little money available to clients.

Second, there are excessive delays in receiving the first payment for people placed in community training homes. According to regional staff and providers, it takes at least three months and as many as nine for a provider to receive the first check after a person is placed in the home. One regional administrator reported that one provider was owed $4,000 before receiving a first check. As regional staff members describe it, this is a major source of frustration and anger among community training home providers. One commented, "We lose a lot of good people."

The community training home program rate system is a "retrospective payment" system. The DMR regions submit monthly invoices for services already rendered. In other words, no paperwork is processed to pay providers until they have had people in their

homes for at least a month. It is also the case that for people funded through AD, this means that DIM does not even determine eligibility until a minimum of a month after placement. Officially, DIM is supposed to determine eligibility within 60 days.

According to different people, there are different sources of excessive delays in payments to providers: social workers, DMR regional business offices, the DMR Central Office, DIM, and computer breakdowns. Of course, the mere number of individuals and offices involved in payment increases the chances of delay.

One DMR Central Office administrator explained that DMR can pay providers until DIM payments are started. However, DMR regional officials do not seem to be aware of this. Administrators in two regions indicated that they have advanced providers funds through money taken from other sources, including respite and money donated by staff. One regional administrator commented, "Money is often late. This part of the system is out of control. . .Some regional centers do creative things to provide that front money. None of this is by the book."

Third, like payments to providers, <u>funding for adaptive equipment is characterized by long delays</u>. Just about all regional administrators and staff complain about excessive delays in obtaining adaptive equipment such as wheelchairs, walkers, bathroom equipment, lifts, special shoes, and similar items. Similarly, families or providers with people with multiple disabilities in their homes

reported that people must wait a long time, sometimes over a year, to receive equipment. During one of our visits to a home, we observed one young woman who had to be tied into an ill-fitted wheelchair so that she would not fall out. Her provider also explained that the only chair she could sit in other than her wheelchair was an old potty chair: "It takes too long to get the special equipment she needs. After ordering shoes, wheelchair, back brace, she waits one year. When she gets them they don't fit a growing girl and she makes do. The commode is also too small. It is the only chair other than her wheelchair that she can sit on. She watches TV while sitting on the commode chair." In addition to long delays in obtaining adaptive equipment, some providers indicated that they had to pay part of the costs for equipment from their own funds.

It is unclear what the reasons are for the long delays in obtaining adaptive equipment for people. Apparently, most of the people placed in community training homes are covered by Medicaid,is administered by DIM. Medicaid can only be used to purchase equipment not covered by other sources.

Fourth, the current funding system provides disincentives for people placed in community training homes to engage in supported work and other paid employment. Since relatively few people living in community training homes currently hold paid jobs, this is not viewed as a critical issue by most regional staff and providers. However, as additional people are placed in supported work and other paying jobs, it can be anticipated that this will become a major problem if not addressed.

As it currently stands, people in community training homes can receive relatively little earned income before their other benefits are affected. One DIM administrator stated that the disregard for earned income is set at approximately $50 per month. According to a DMR administrator, DMR does not have a policy on this, but may reduce benefits on an individual basis.

A couple of providers expressed strong reservations about supported work. One stated, "I refuse to consider a supported work placement as it plays havoc with their financial set-up." Another provider had to pay $59.40 on a client's behalf when the client was informed that she had received an overpayment in SSI due to her work placement.

Recommendation 5A: DMR should develop a single, simplified rate level system for the Community Training Home program.

From practically any standpoint, the current rate system forcommunity training homes is clearly inadequate. We recommend that DMR establish a single rate reimbursement system for community training homes. The single system should not differentiate between people who receive funds from AD through DIM and those who do not. In other words, the rate should not be based on the funding source (DMR funds, SSI, AD). Thus, DMR should establish the single rate system and should pay the difference between the rate and funds available from other sources.

In developing a single rate system, we recommend that DMR consider three "levels of care" (high, medium, low) as opposed to the five current levels. It is unclear whether practical distinctions can be made among five levels with any degree of precision. In addition, in the absence of a clear rationale or justification for assigning different rates to children and adults, we recommend that children and adults be covered under the same rate system.

Recommendation 5B: The rate levels should be used to set regional allocations of funds for the Community Training Home program, rather than being used to determine the rates received by individual homes.

Consistent with DMR's movement toward greater regional authority, we recommend that the regions be given greater flexibility to set the payments received by individual community training homes. The rate levels would be used to set regional allocations for the community training home program. Within the regional allocation, the regions could determine an appropriate rate of payment for individual homes. Whereas under the current system regions must request an exception from Central Office, this recommendation would enable them to set a reasonable rate based on local needs and individual circumstances. In implementing this recommendation, DMR might establish a minimum rate to be paid to community training homes.

Based on our review of the Community Training Home program, we are not convinced that additional funds are necessary for reimbursement for providers. While DMR's current rates are approximately $5 to $10 lower than the rates for Macomb-Oakland's (Michigan) successful community training home program, most providers seem satisfied with their rate of payment. However, we believe that it essential to have a flexible system to enable regions to pay high rates under special circumstances. For example, some professionals (e.g., nurses) who might be desired for people with challenging needs might pursue other careers if the rate of reimbursement is not sufficiently high.

Recommendation 5C: DMR should implement a prospective payment system.

We recommend that DMR arrange to pay providers immediately upon placement. Ideally, both DMR and DIM should provide prospective payment to providers. We have been informed that DMR and DIM have begun discussions on the application process for AD and we recommend a continuation of these discussions. However,failing agreement by DIM to implement a prospective payment system, we recommend that DMR pay the AD amount while applications are processed and be reimbursed at the appropriate time.

Recommendation 5D: DMR should assure a standard personal allowance for all people placed in community training homes.

We recommend that all people placed in community training homes receive the same personal allowance. This should be set at at least the current DIM personal allowance of approximately $100 per month. It is not self-evident that adults require a higher personal allowance than children. Nor does it seem equitable for people eligible for AD to receive a higher personal allowance than people who are not.

Recommendation 5E: DMR should insure that people placed in community training homes receive the appropriate adaptive equipment at the earliest possible time.

In light of the lengthy delays in obtaining Medicaid funding for adaptive equipment, prescribed by competent professionals and recommended by regional teams, we recommend that DMR pay for adaptive equipment directly in those instances in which Medicaid or other funding can not be accessed in a reasonable period of time. Of course, DMR should be reimbursed for costs incurred once other funding sources have approved the equipment. As a long-term solution to this problem, we recommend that DMR collaborate with DIM to reduce the unreasonable delays in obtaining adaptive equipment.

Recommendation 5F: DMR should insure a reasonable earned income disregard for people placed in supported work placements or other paid employment.

We understand that DIM has agreed to propose a new regulation to

increase the earned income disregard "to encourage recipients of State Supplement Program for Disabled Individuals to participate in gainful employment without losing benefits." Under the proposed regulation, the earnings disregard will be increased to $65 plus one-half of the balance to a maximum disregard of $200. We recommend that DMR adopt the same policy officially regarding DMR payments through the community training home program.

Recommendation 5G: DMR regional administrators and staff involved with the Community Training Home program should receive ongoing training and information on fiscal issues related to the program.

It is essential that DMR regional administrators, case managers, and other appropropriate staff have current and accurate information on DMR and DIM funding issues, including the rate system, the personal allowance, income disregards, and procedures for obtaining adaptive equipment.

Respite and Supports

Problem 6. Community training homes do not receive adequate supports necessary to insure successful placements.

If there is any issue on which DMR regional staff and providers

agree, it is that community training homes are not provided with adequate respite and supports. Each regional administrator and case manager interviewed during this evaluation recommended additional resources for respite and supports for community training homes. While a small number of providers indicated that they are getting by without respite and other support services from DMR, most expressed frustration and sometimes anger over the lack of supports available to them. As they stated, "I'm on my own." Several providers used the phrase "burnt out" to describe their current feelings.

As with other aspects of the Community Training Home program, the availability of respite and other support services varies widely by region. A DMR document dated November, 1985 indicated that of the nine previous DMR regions with a "specialized" community training home program (three were reported to have no program), four expected providers to pay for respite themselves, four paid for respite up to 14 days per year, and one contracted with a private agency that billed providers directly. During interviews, regional administrators and case managers explained that respite is sometimes available at the regional center and, to a lesser extent, in group homes and respite community training homes. Some regional administrators also indicated that funds were available for home health aides. An administrator in one region explained that Title XIX (Medicaid) paid for home health aides for up to 20 hours per week for people over 18. In another region, an administrator stated that the region had a contract for home aides, but that the funding was running out.

DMR has begun to allocate additional funds for respite. These funds may be used to support either community training homes or families. One regional administrator stated that 20% of the respite funds in that region were earmarked for community training homes.

The issue of respite for community training has received considerable attention in Connecticut. Many individuals and groups have made recommendations for respite. Recently, a Community Training Home Respite Task Force composed of providers, DMR Central Office and regional staff, and a respresentative from the ARC issued a set of recommendations to the Commissioner. The Task Force recommended, among other things, that the Commissioner develop a mechanism to grant individual waivers to allow certain providers to accomodate more than three persons for short periods of time and to guarantee to each provider a minimum of 20 days paid respite per year. In response to this first recommendation, the Commissioner indicated that he did not have the authority to waive state fire code regulations. In response to the second, he indicated that effective immediately community training home providers could have 20 days off per year with pay, upon regional approval, but did not guarantee that DMR would pay for this respite.

In the course of the interviews, DMR regional administrators and case managers offered recommendations on respite and supports for community training homes. While some pointed to the need for additional in-home relief, most stated that more out-of-home respite

was needed. Many indicated that more respite should be available at the regional centers. One commented, "We need back-up respite on the units here at the center." Another said, "We need respite at the center on units for medically involved people." In a memo, another regional administrator recommended that one regional center or group home bed be set aside for every 20 community training home clients. A couple regional staff members stated that the current rate for community training home respite should be increased from $20 per day.

During the interviews, some providers stated that they need more out-of-home respite arranged by DMR. Several mentioned that they have never been away from the people living in their homes except for a few hours and would like to have a break or vacation. As one stated, "They burn out homes because there's not enough support services." This provider also added, "There's not enough respite, but if I fight for it, I might get it." Others expressed concern over what would happen to the people in their home in an emergency. One of these providers stated, "There's no provision in an emergency. . .They don't support those who are willing to do things for people."

While some providers want DMR to provide a guaranteed number of vacation days, most of the providers interviewed neither want nor need DMR to provide out-of-home respite. Several stated that they preferred to have their own families and friends provide respite, but that they had to pay for this themselves or had to expect these people to provide respite at no cost (one expressed a reluctance to ask neighbors for help because they refused to be paid and she did not

want to impose upon them). In fact, out of 19 providers or families interviewed, nine stated that they look to family and friends for respite or would turn to them in an emergency. Some of the families expressed resentment with DMR for not providing support for them to obtain respite from their own social networks. One woman said, "To go on vacation, we wanted to get respite from our friends, but couldn't. We were offered the institution instead." Another stated, "A stranger can take of my kids, but not my daughter, (who is like) their sister. They can't stay in her home without me." A third person explained, "We won't leave them with just anybody."

Rather than out-of-home respite, many families want in-home relief and a range of other supports. Some families expressed opposition to out-of-home respite, in general, and institutional respite, in particular. One family explained, "They should provide in-home respite so that little children don't have to leave their homes." Another said, "I could send my kids to the regional center, but this is their home and I don't want to break up my family. . .I don't leave my children for more than two nights and three days, ever. I couldn't ever leave my family too long." A third family expressed the same sentiment, "We don't believe in respite. Don't disrupt. Let them stay in their own home. Don't bounce kids any more. Give them stability and consistency." A fourth family indicated that they would reject institutional respite even in an emergency: "In an emergency they expect us to use the regional center, but we won't listen to it."

Most families or providers have to pay people to come into their homes out of their own money or find people who do not have to be paid. One family with two children with severe disabilities stated that they pay a babysitter $50 every few months: "We need in-home respite with someone we trust. Give me the money to pay my babysitter." A family with three children with severe medical involvements pays a special education teacher to come into the home 40 hours per week.

According to the providers, they must pay for a number of other things themselves. Either that or the families or the people placed there go without. Thus, families or providers have bought walkers for people, paid for special diets and diapers for older children, and purchased necessary appliances such as humidifiers. One family hired a music therapist to work with a child. Another paid for consultation on behavior management at an out-of-state institute. One of these families stated, "We have to provide everything special they need. . .DMR doesn't extend itself to offer resources. Nothing is forthcoming." Another family said, "We're spending much more than we receive from DMR. . .We put the money into the kids."

In short, providers or families have a range of needs. Some need out-of-home respite arranged by DMR. Others could use financial support for respite arranged by themselves. Still others need in-home support or at least assistance in paying for people to come into the home. And others have a variety of miscellaneous expenses associated with having people placed in their homes. In designing support services, it is important not to think solely in terms of vacations or

guaranteed days off, but more broadly in terms of the range of things necessary to insure successful placements.

If some of the current providers do not receive additional supports, DMR runs the risk of losing some of its finest homes. Clearly, in the absence of expanded support services, the community training home program can not be looked to for a significantly greater number of people.

Recommendation 6A: DMR should allocate additional funds for respite and supports for community training homes to each region, based on a standard rate for each person.

In order to support the placement of people with mental retardation in community training homes, DMR should provide adequate funds for respite and other formal and informal supports. We recommend that funds be allocated to the regions for respite and other supports based on a standard rate per person placed in community training homes. This rate should be set at at least $100 per person per month or a total of $1,200 per person annually. Note that this figure refers to the regional allocation and not the amount of funds spent on any particular community training home. With these funds, regions should provide respite and support services, as described below.

While we recognize the budgetary implications of this recommendation (approximately $575,000 annually), we also believe that the Community Training Home program is worth the investment from an

economic, programmatic, as well as an humanistic perspective. The placement people with mental retardation in community homes is less expensive, or more cost-effective, than institutions, group homes, or any other residential placement. It should also be noted that, in a previous section of this report, we did not recommend an increase in funds allocated for the payment of providers.

Recommendation 6B: By policy, DMR should direct the regions to establish a flexible and individualized support program for community training homes.

We recommend that DMR develop policies to require regions to develop and implement an individual plan for each community training home to provide respite and other formal and informal support services. With the funds described above, the regions would pay the costs of respite and other support services, based on the individual needs of the families and people placed in their homes.

The policies should address the following areas:

(1) They should list the range of support services that can be paid for with respite and support services. We recommend the following: out-of-home respite, in-home respite, sitter or companion services, homemaker services, home health aide, social and recreation programs, family or provider training, home modifications (e.g., ramps), special equipment, clothing or appliances not funded by other sources,

transportation, and other goods or services that will support the family

(2) The policies should require that regions develop an individual support plan for each community training home, in conjunction with the "Overall Plan of Care," and that, in developing the plan, regions should assess the needs of both the provider and the client and should, to the extent possible, support natural networks.

(3) They should authorize both the direct payment for goods or services by the regions and reimbursement of expenses incurred by families or providers for goods and services in accord with the plan.

(4) The policies should confirm the Commissioner's previously expressed commitment to authorize providers to take up to 20 days off, and more under exceptional circumstances, without a loss of reimbursement, with regional approval.

(5) The policies should require that all respite and support services be offered in a manner consistent with DMR's Mission Statement. Specifically, we recommend that the use of regional centers for respite be halted. In addition to the fact that some families are strongly opposed to institutional respite, we believe that the use of regional centers in this manner runs counter to DMR's Mission Statement and, in the long run, interferes with the

development of regional capacity to support people with challenging needs in the community.

(6) They should reiterate and confirm Section 19a-467-3(7) of DMR Regulations that reads: "When the licensee is absent, he shall provide for a competent and responsible person to be available at all times when any individual or group of residents is present in the facility, to be responsible for the conduct and safety of any resident until the return of the licensee." DMR regulations explicitly authorize community training home providers to arrange for "competent and responsible" people to supervise people placed in their homes in their absence. We believe that payments to these persons, through reimbursement of providers, should be provided.

In making this recommendation, we are underlining the importance of meeting the individual needs of community training homes, both providers and people placed there. As we have explained, some homes providers express a need for respite and a guaranteed number of days off and want DMR to arrange for this. However, many, probably the majority of families, do not fall into this category. Some prefer to use family members, neighbors, or friends to provide relief, while others need other kinds of support. We are recommending that DMR adopt a flexible and individualized approach to supporting community training homes.

Recommendation 6C: DMR should require the regions to submit to Central Office and, upon approval, implement a plan for respite and support services for community training homes.

In a previous section, we recommended that the regions develop annual plans for the operation of the Community Training Home program. As part of this plan, regions should address how they will provide respite and other support services to these homes.

We believe that regions should address the following issues:

(1) The regions should specify the minimum and maximum amount of funds that will be spent of respite and other supports for each community training home. We believe that the regions are in the best position to set these amounts.

(2) They should specify how they will identify the needs of community training homes and their existing social networks.

(3) The regions should specify what kinds of respite resources will be used or developed (e.g., contracts with private agencies, respite community training homes). In addition, they should indicate what rates they will pay for out-of-home respite. We would encourage regions to increase the current respite community training home rate of $20 significantly (the rate should be sufficiently high to encourage respite providers to maintain "vacant beds"). The

regions should also indicate how they will phase out the use of regional centers for respite.

(4) For families who prefer to use family members or friends for out-of-home respite, regions should describe expedited licensing procedures to enable these persons to qualify as respite providers. While DMR regulations permit persons selected by providers (who are "competent and responsible") to provide in-home respite, the use of unlicensed homes to provide out-of-home overnight respite with DMR funding raises difficult questions. As an alternative, regions should develop an expedited licensing process for people identified by providers.

Training for Community Training Homes

Problem 7. Community training home providers do not receive adequate training.

The regions vary widely in terms of the training provided to community training homes.

Most regions offer approximately eight weeks of initial group training to providers. Each region develops its own curriculum. Depending on the region, the training covers such topics as first aid, behavior modification, licensing procedures, fire safety, history of mental retardation, record-keeping, sexuality, the definition of mental retardation, the role of the community training home provider,

behaviors of the mentally retarded, the overall plan of care, and normalization. Some regional training includes a tour of the regional center. One region gives providers a manual in lieu of group training. This manual, which is composed primarily of reprinted articles, covers a broad range of topics, including definitions of mental retardation and developmental disabilities, first aid, behavior management, foster parenting, and a host of other topics. At least several previous DMR regions have not offered any training to providers.

Community training home providers, or families, express different perspectives on training. Several stated that they found the training helpful. One, in particular, indicated that the training helped her overcome some misconceptions about people with mental retardation. Most did not express strong feelings about the training one way or another. Those who had received training typically stated that it was OK, but that they learned "nothing new." Those who had not received training stated that they did not want any. As one provider commented, "Training is not essential, loving the children is." Another said, "All you need is common sense." Finally, some families, four with children, made suggestions on what they think should be covered in training. Several of these families stated that they would like more information on community resources and services for children. One of these remarked, "DMR doesn't provide information on anything." A couple of these families indicated that they would like more "hands-on training" and opportunities to "problem-solve" on issues surrounding their particular children.

In looking at the training offered to community training homes, a number of problems become apparent. First of all, and most obvious, some families receive no formal training or orientation whatsoever. Some of these families are classified as "regular" and some as "specialized." For those families who are provided a manual in lieu of formal training, it cannot be assumed that they actually read the manual. In fact, many of the articles in the manual are not written for the average person.

Second, as noted in an earlier section of this evaluation, when regions do offer formal training, the training is designed for homes with both children and adults. As a result, providers or families either receive irrelevant information (e.g., information on educational services for homes with adults) or are taught inappropriate expectations for the people in their homes (e.g., information on foster parenting and foster children for adult homes).

Third, as far as can be determined, no region requires ongoing training of community training homes. Even those regions that offer initial training do not require providers to receive updated training. According to most regional staff members, this is a major shortcoming of the community training home program. One social worker stated, "Providers need more ongoing training." Another said, "Relicensing every year should be tied to coming to mandatory inservice programs." Some regional staff members indicated that they could not get providers to attend inservice training sessions. As one expressed it, "These events have notoriously poor attendance." One regional administrator related that she was told by Central Office

that she could not require providers to attend inservice training sessions.

Although regional administrators and staff stated that they could not require providers to participate in onoing training, DMR regulations explicitly require participation in inservice training. Section 19a-467-3(a)(3) reads: "The licensee shall attend designated in-service training sessions that are provided or approved by the department."

Fourth, based on information on community training home training in three previous regions, the goals and objectives of the training seem unclear. The training schedules for three regions list a series of guest speakers addressing a broad range of topics. While some of these topics may be important (e.g., sexuality, normalization, first aid), the training as a whole is disjointed. The training does not seem to distinguish between things all providers should know and things that only a select number need to know. For example, "taking rectal temperatures" is a topic listed on one region's training schedule.

Fifth, the training is out of step with DMR's Mission Statement. When regions offer training, they devote insufficient attention to community integration and participation in community life. Except for a brief session on deinstitutionalization or nromalization, the training does not address the importance of helping people with mental retardation to lead typical lives in the community. Thus, several of the providers interviewed during this evaluation expressed negative stereotypes of the mentally retarded.

At the same time, some of the training conveys information that is irrelevant, at best, and negative, at worst. It is unclear why providers need to know about "definitions of mental retardation," "levels of retardation with varying diagnoses," or " problematic behaviors," apart from individual people. Indeed, this kind of information sometimes reinforces negative attitudes and stereotypes. Some of the information provided in at least one region is not only negative, but potentially harmful. A manual in this region reprints an article on "severely disruptive clients" that prescribes a number of aversive interventions, including "noxious substances such as lemon juice" and "shock."

Finally, not all regions provide specific training to community training homes on an individual basis. The regions vary in terms of the availability of competent staff to train providers or families on meeting the specific needs of people living in their homes. Where training is provided, this is usually done by a behavioral specialist, nurse, or, to a lesser extent, social worker. However, at least some regions have not had specific staff assigned to the community training home program to work with homes. Several regional staff members pointed out that this made it difficult to serve people with severe disabilities or complex needs.

Recommendation 7A: By policy, DMR should require regions to develop separate training programs for community training homes for adults and children to assure that all providers or families receive both initial and ongoing training.

In accord with its regulations, DMR should develop policies to require mandatory training for community training homes on both an initial and ongoing basis. For reasons described previously, training should be provided separately for homes for children and those for adults. For families for children, the training should cover the DMR Mission Statement, permanency planning, subsidized adoption, educational rights, relations with natural families, information resources, and other key issues. For homes for adults, the training should focus on the DMR Mission Statement, the use of generic resources, age-appropriate activities and expectations, supported work, and related issues.

Recommendation 7B: DMR should require the regions to develop and, upon Central Office approval, implement an annual plan for training the community training home providers.

As recommended earlier, we believe that DMR should require the regions to develop an annual plan for the operation of the community training home program, consistent with the policies described above. This plan should include training of community training homes. In developing this plan, the regions should address the following issues:

(1) Goals and objectives for the training.

(2) Timelines for initial and ongoing training.

(3) Tentative schedules and listing of topics (including the issues described above).

(4) Procedures for providing individual training on meeting the needs of specific people placed in community training homes.

Monitoring of Community Training Homes

Problem 8. Community training homes are not adequately monitored to safeguard the rights of people placed in them and to insure a high quality of life.

On a statewide basis, the community training home program is characterized by a lack of monitoring. In other words, there are insufficient safeguards to assure that people's rights and welfare are protected.

As a requirement, regions are only obligated to review community training homes as part of licensure. However, this only occurs once a year. In addition, the licensure standards and forms focus on fire safety, environmental, and record-keeping aspects of community training homes. Even in terms of the annual licensing, some regional staff members report that they have difficulty enforcing standards. One regional person in charge of licensing explained, "There are always problems in relicensing. They have problems keeping records."

Presumably, case managers are responsible for the routine monitoring of community training homes. As a general rule, case managers do not have an active presence in these homes. Of course, this varies widely from region to region and case manager to case manager. One region seemed to be a bit more aggressive than others. An administrator in this region indicated that case managers usually call or visit each home twice a month. A case manager in the region stated, "The whole team watches what goes on and tells each other. . .I learned that I have to spend time alone with each client, not at

work or at home. I go to lunch with someone almost every day. We get to know each other." Most case managers do not seem to be as involved with community training homes. One regional administrator said, "We have no written policy on visiting the homes, but case managers try to visit every other month." A case manager in another region stated that she is not required to visit homes, but makes a point of visiting them every three months. Another regional administrator explained that every other "OPC" meeting is held at the community training home.

When speaking with providers or families about their case managers, it becomes clear that case managers play an extremely passive role with the community training home program. They are available when called upon, but do not seem involved with the homes otherwise. Most providers stated that they are satisfied with their case managers. Asked how often they see or talk to them, they typically answer, "Whenever I call." One provider after another gave the same response: "Whenever I call, about one or two times a month," "She's a phone call away." "Anytime I need him; I call and he comes," "I call them," "Whenever I need help, she usually helps; I see her whenever something comes up, otherwise once a year," "Not too often, I would call as a last resort," "I call her a lot; she's always available," "Whenever I call," "I see or talk to them monthly; I bug them."

Some express dissatisfaction with their case managers. In response to being asked how often she sees her case manager, one said, "As little as possible." Another stated that she was "about ready to shoot" her case manager because of "ineptness." She added, "There are not enough people trained well enough to be training me." A third

family indicated that case managers were not helpful, but sympathized with them: "If they don't come, I go see them. Their hands are tied. They can't accomplish much. They can't act on your needs. Everything takes too much time." Finally, one family expressed deep frustration with the passive role adopted by case managers: "Maybe I expect too much. Why doesn't he inquire about the person more than just a meeting every three months? I don't know what's available. Can't he investigate something without being asked? I'm not clear on the role. I don't know what their job is and what they're supposed to offer."

In short, while there are exceptions, case managers do not seem to initiate involvement with community training homes or the people placed there. While relatively few homes are closed because of abuse or other shortcomings (seven in the past year), the community training home program is still open to abuses of both a subtle and blatant nature.

It should be added that case management loads for community training homes are of manageable size. According to regional administrators and case managers, the average regional case load ranges from 1:30 to 1:22, with the typical case manager having roughly two dozen clients (because of several people placed in one home, this can work out to as few as a dozen homes). This case load is comparable to Macomb-Oakland's, where case managers typically visit each community training home at least monthly.

Recommendation 8A: By policy, DMR should require that each community training home is visited at least monthly.

In order to safeguard the rights and well-being of people placed in community training homes, DMR should require that each home be visited at least once a month, in addition to other contacts with the home or the client. We believe that the current case loads of regional case managers should permit this level of involvement in the homes. In addition to serving a monitoring function, these visits will also enable case managers to provide more effective support to providers and clients alike.

Recommendation 8B: DMR should require the regions to develop and, upon approval, implement plans to monitor community training homes.

As part of a community training home plan, the regions should prepare a plan to monitor homes. This should include:

(1) Guidelines regarding announced versus unannounced visits.

(2) Guidelines regarding the times of the day and days of the week visits are made.

(3) Guidelines for speaking to clients in private, where possible.

(4) Guidelines for addressing violations of DMR policies or regulations.

Training for Regional Staff

Problem 9. Regional staff members assigned to the Community Training Home program do not receive adequate training.

Regional administrators and other staff assigned to the community training home program do not receive adequate training, if any. Any accomplishments associated with the community training home program have occurred in the absence of DMR guidance, support, and leadership.

Regional administrators, case managers, and other staff need regular and ongoing training and information on state regulations and policies, the DMR Mission Statement, and effective practices for supporting people with mental retardation in community training homes. As one case manager put it, "We need more information and inservicing and more training than being showed a form."

In the course of this evaluation, we identified many areas for training of regional staff. First of all, all regional staff members need to know and understand DMR's recently enacted Mission Statement. It is clear that many administrators and other staff do not share the vision set forth in the Mission Statement. Many expressed perpsectives at odds with the Mission Statement. Throughout the regions, community services staff members, including those assigned to the community training home program, continue to view institutions, or regional centers, as a "back-up" for community programs. When people need respite, they look to the regional centers. When placements do not work out, they often seek institutional admission, rather than

identifying the supports people need to live successfully in the community. Thus, most regional staff members interviewed stated that people with challenging behavior were inappropriate for community training homes. In one region, several administrators and case managers stated that these people need psychiatric care in mental hospitals or intensively staffed group homes. Similarly, some regional staff members do not appreciate the meaning of community integration endorsed by DMR's Mission Statement. Commenting on transportation problems with community training homes, one case manager stated, "There are no vans available to pick up and transport people around. We need to locate community training homes in clusters and pool the use of a van."

Second, in line with the first point, regional case managers and other staff need training on how to incorporate the Mission Statement into individual plans (the "OPC" or "OPS"). In other words, regional staff should encourage, support, and reward community training home providers or families to help people living in their homes to become part of the community, to make choices, to develop competence, and so on.

Third, in view of the complex nature of the funding system for community training homes, DMR regional administrators and staff need current and accurate information on the rate structure, personal allowance, income disregard, and other fiscal issues.

Fourth, regional staff members should be trained in providing respite and other supports to families, with an emphasis on using existing resources and social networks.

Fifth, consistent with our recommendations on children, regional

staff members need training in permanency planning and adoption, including DCYS adoption procedures.

Finally, regional administrators, case managers, and other staff would benefit from practical information on sound practices for the operation of the community training home program, including the placement of people in community training homes, training of families, monitoring, the use of generic health services, and recruitment strategies.

In regard to placement, regional staff should receive guidance on the placement of adults and children within the same home and on interracial placements. Currently, some regions make interracial placements, while others do not. This is an issue that requires careful consideration and discussion from a variety of perspectives, including the perspectives of members of racial and cultural minorities.

In regard to recruitment, regional administrators need information on effective ways of identifying new providers or families. According to regional administrators and staff, most of the recruitment is currently done through "word of mouth" and, to a lesser extent, classified ads on specific people. While "word of mouth," or informal contacts, may yield the greatest potential for identifying new families, the regions could adopt a more aggressive approach in "spreading the word." In addition, Macomb-Oakland and other places with a successful family care program have found that general classified ads, brochures, and other strategies are effective in recruiting new families. The classified ads directed at recruiting families for specific people are probably not as effective as other

approaches and can cast individuals in a negative light. For example, a classified ad prepared by one region read: "Share your home with a non-ambulatory (wheelchair), profoundly mentally retarded 6-year-old girl with hearing and visual impairments. Requires someone able to give total physical care. Child is Hepatitis B carrier. Free immunizations will be provided to entire family. Earn $1000 per month tax free." Another read: "Share your home with a blind, non-ambulatory (wheelchair) 17 year-old-boy with mental retardation. Requires someone able to give total physical care who is comfortable with stomach feedings. Earn $1000 per month tax free."

Since some regions experience high turnover in case managers, it is important that training be provided on a regular and ongoing basis.

In providing training to regional administrators and staff, it should be noted that many DMR staff members possess considerable competence and can be called upon to share information on effective practices for supporting people in community training homes.

Recommendation 9A: DMR should provide annual intensive training to regional administrators, case managers, and other professional staff assigned to the Community Training Home program.

We recommend that DMR provide an annual training workshop on the community training home program for regional staff. This workshop should be at least one week long and should be mandatory for all regional staff assigned to the program. In accord with the discussion above, the training should include the DMR Mission Statement, individualized planning, permanency planning and adoption, respite and

support services, fiscal issues, recruitment, placement policies, monitoring, training of providers or families, the use of generic resources, and other issues identified by regional staff or the Central Office.

Recommendation 9B: DMR should host and staff bimonthly meetings among all regional Community Training Home program coordinators.

To provide a forum for sharing information on statewide policies and issues and effective practices, DMR should host regular meetings among the regional coordinators. Previous meetings among the coordinators were discontinued due to a "lack of leadership." With increased Central Office leadership and a clarification of the authority of the regions, these meetings can be reinstated. The Central Office should play a leadership role in organizing these meetings.

Recommendation 9C: DMR should require the regions to develop and, upon approval, implement a plan for providing ongoing training to regional staff assigned to the Community Training Home program.

In order to insure that regional staff receive adequate preservice and inservice training, DMR should require the regions to develop a plan for staff training on the community training home program, in addition to the annual intensive workshop. This will insure that newly hired staff receive an adequate orientation and training and that all staff members receive ongoing information on

state policies and effective practices.

Regional Accountability

Problem 10. The Community Training Home program lacks accountability.

The community training home program can best be described as a laissez-faire program. Regions have been left on their own to develop the community training home program with no statewide accountability.

As far as can be determined, Central Office has not been involved in reviewing regional community training home programs. During interviews with regional administrators and staff, not one indicated that Central Office had ever reviewed or monitored their community training home programs.

As indicated throughout this report, the community training home program is characterized by numerous problems on a statewide basis: lack of training and support services for community training homes, excessive delays in obtaining necessary adaptive equipment, lack of aggressive case management and monitoring of homes, and so on.

In the course of our visits to homes and interviews with regional staff and providers, we came across many positive things and some negative ones as well. Some regions did not follow state regulations in regard to training of providers and other aspects of the community training home program. Some of the homes were far from ideal. For example, one home did not meet acceptable standards of

cleanliness, several providers expressed negative stereotypes of people with mental retardation, and a couple of regional staff members complained that some providers do not take people to medical and dental appointments. A few of the regional staff did not seem to perform their role with competence and commitment. One case manager talked a family out of considering adoption for a child because they would lose financial reimbursement. This same case manager told another family that community training homes should be viewed as a business. One region had long delays in forwarding "OPC's" to community training homes after the annual review. Thus, we obtained copies of three plans that were sent to providers in February and March, 1986 for meetings that were held in August, 1985. In addition to our observations and interviews with providers and regional staff, other persons familiar with the community training home program have expressed concerns about fire safety, medications, and programming in community training homes.

In short, despite many excellent homes and many capable regional staff members, the community training home program is open to serious problems.

Recommendation 10A: DMR should establish a statewide quality assurance system for the Community Training Home program.

In order to insure regional accountability for the community training home program, DMR should develop and implement a quality assurance system. The system should be designed to evaluate regional programs according to DMR's Mission Statement, regulations, and

policies. The quality assurance system should include a review of regional plans, as described in previous sections of this report, and a review of a random sample of community training homes within each region (these reviews should include observations of the homes, interviews with providers and clients, and inspection of plans and records). The quality assurance system should be used to evaluate regional performance and to identify areas for training and technical assistance.

Recommendation 10B: DMR should require regions to develop and, upon Central Office approval, implement a regional quality assurance system for the Community Training Home program.

As part of the annual plan for the operation of the community training home program, which we have recommended, the regions should prepare specific plans to evaluate the quality of their programs beyond annual licensing and routine monitoring by case managers. These plans should include:

(1) Procedures for an independent (i.e., separate from the respective case manager) evaluation of each home at least annually.

(2) Procedures to evaluate the homes according to DMR's Mission Statement, regulations, and policies.

(3) Procedures to maximize parent, consumer, and provider involvement in the review of the homes.

Expansion of the Community Training Home Program

Problem 11. The Community Training Home program is underdeveloped.

The community training home program has the potential of serving a significantly larger number of people in Connecticut. For children, in particular, community training homes are a preferred alternative to institutions, group homes, nurseries, and other residential placements.

There are currently approximately 164 children and 314 adults placed in community training homes in Connecticut. According to figures provided by DMR, a relatively large number of vacancies exist in licensed homes. As of February, 1986, five of the six current DMR regions reported 22 vacant licensed homes and 61 vacant licensed "beds" in community training homes. In addition to current vacancies, most regional administrators stated that they believed they could recruit additional homes if necessary.

From the vantage point of regional staff, the major barrier to placing more people in community training homes has been a lack of a sufficient number of staff. One regional administrator stated, "Unless I get more staff, I'm not setting up the five or six families already recruited." They reported that they needed additional case managers, trainers, behavioral specialists, nurses, and other professionals. Some of them stated that they regularly borrowed nurses and other professional staff from other regional programs. A couple regional staff members also said that they need more

secretaries to help with the paperwork associated with the community training home program.

While regional administrators and other staff stated that the community training home program has been understaffed, most also indicated that they had been informed that additional staff would be coming to the program. Some were enthusiastic about getting more staff, while others were cynical. One regional staff member stated, "I was told we're getting more staff in July, but a lot of Julys have come and gone. I've been told things so often that I don't believe them any more."

It should be noted that many families are doing an outstanding job of serving adults and children with severe disabilities in their homes in the absence of DMR support. In fact, of the 19 families interviewed, six had children with severe medical involvements of challenging behavior. This, in itself, speaks in favor of expanding the community training home program.

Recommendation 11A: DMR should allocate sufficient staff resources to enable the expansion of the Community Training Home program, provided that major changes are made in the operation of the program.

While additional staff have been allocated to the regions for the community trraining home program, it is unclear whether these staff positions will be sufficient to enable the expansion of the program. We recommend that DMR review staff resources in each region to assure that each region has at least one full-time professional

assigned to recruitment and licensing, case managers assigned at a ratio of no more than 1:25, and nurses, program specialists, and other professionals available to community training homes.

We believe that the community training home program should be expanded, but only if changes are made to address the problems identified in this report. As one regional administrator explained, "It is a very good program. It's just that the weaknesses are of concern to me. It is a good program, but we need to look at it if we want to expand."

AN ADDITIONAL ISSUE

In concluding this report, we want to address one additional issue that arose repeatedly during our evaluation. Since the issue is not directly related to the community training home program, we are not making any formal recommendations in raising it.

Throughout this report, we have stated that for children, foster home placement is the preferred alternative to any other out-of-home placement. Whenever possible, however, children should live with their natural families or with adoptive families.

In line with our recommendation on permanency planning, DMR should devote greater attention to supporting natural families. Just as DMR has begun to devote additional resources to the community training home program, it has begun to make additional funds available for respite for natural families. By all accounts, these funds are inadequate to meet the needs of families with children with developmental disabilities at home.

In the course of our evaluation, numerous regional staff and providers stated that while community training homes have not received much support, they have received more than natural families. As one family said, "By the time I meet the parents, they're already burnt out." She added that parents should receive more respite and home training.

As DMR strengthens the community training home program, it should strengthen supports to natural families. Many of the recommendations in this report are relevant to families. Consistent with permanency planning, DMR staff members should work to maintain family ties and, whenever possible, to reunite families. Further, like community training homes, natural families have a range of needs and can benefit from an individualized and flexible family support program.

While for children, foster placement is to be preferred over group homes, institutions, and other residential settings, it is a poor second choice to being able to live at home with their families. A stable home should be the goal for every child.

APPENDIX: EVALUATION METHODOLOGY

The evaluation was designed to be both "formative" and "qualitative." By "formative" (as opposed to "summative"), we mean that we were interested in examining how the community training home program works and exploring ways it might be strengthened. We were especially interested in administrative, fiscal, philosophical, and programmatic aspects of the program. By "qualitative" (as opposed to "quantitative"), we mean that we attempted to learn about the community training home program from the various perspectives of DMR staff, providers, and others, as expressed in their own way and withtheir own words. All interviews were conducted based on an open-ended guide, rather than a structured instrument or rating scale. As additional topics arose during the interviews, these were pursued.

The evaluation was based on a review of documents, visits to community training homes, on-site interviews, and phone interviews, as described below:

1. Review of documents. As part of the evaluation, we reviewed a range of official and unofficial documents and materials, including DMR regulations, DMR reimbursement rate information and schedules, memoranda between regional and central office staff regarding community training homes, training schedules from two DMR regions, a training manual used by another DMR region, minutes and materials from the Community Training Home Task Force, along with the Commissioner's

response to Task Force recommendations, correspondence and other written information provided by several community training home providers, audits conducted by the Mansfield case monitors, a DMR description of the community training home program, numerous miscellaneous DMR plans, budget requests, and other information, and information on an adoption project sponsored by the Department of Children and Youth Services.

2. Demographic information. At our request, DMR collected demographic information on community training homes from each of the six regions. This information included a breakdown of people placed in community training homes by age and mental retardation level, breakdowns on issues such as placement in community training homes over the past year and the number of licensed homes and beds that are vacant, and a listing of actual gross monthly amounts provided to community training homes.

3. On-site interviews with DMR staff. The evaluation included two visits to Connecticut. The first included a interview with three DMR regional staff, including a regional director and two staff members familiar with the community training home program in two previous DMR regions, in a single region. The second included interviews with ten DMR staff from two current (three previous) DMR regions, including case managers, a nurse, a behavior specialist, community training home coordinators, and a director of social services.

4. Visits to community training homes. The evaluation included visits to nine community training homes located in two current and

three previous DMR regions. Eight of these homes were selected by DMR regional staff who were asked to arrange visits to homes they considered "most and least successful." DMR staff members were present during these visits and this may have influenced what providers said during these visits. A visit to one additional home was arranged independently.

5. Phone interviews with community training home providers. Based on a list of providers provided by DMR, we conducted phone interviews with a random sample of providers from different DMR regions. We also conducted phone interviews with two additional providers suggested by other providers. A total of ten providers were interviewed by phone. An additional seven providers could not be reached.

6. Phone interviews with DMR regional staff. We conducted interviews at least one staff member familiar with the community training home program in each of the six current DMR regions. These were selected by DMR.

7. Phone interviews with other knowledgeable persons. We conducted phone interviews with 11 additional people identified as being knowledgeable about different aspects of the community training home program. These included three DMR staff, a Department of Children and Youth Services staff member, a staff member of the Department of Income Maintenance, and five representatives of parent or advocacy organizations.

After collecting all of the evaluation information, the evaluation team held a full-day meeting to review findings and agree on recommendations.

In addition to this evaluation, it should be noted that the Center on Human Policy's Community Integration Project and Research and Training Center on Community Integration, both sponsored by the National Institute on Handicapped Research, are involved in an ongoing study of model community living arrangements and family support programs nationally. We have drawn on information gained through this ongoing study in developing the recommendations contained in this report.

We would like to thank Linda Goodman of Connecticut Department of Mental Retardation for coordinating visits to regional offices and community training homes, collecting background information on the program, and assisting in the identification of regional staff and providers for the phone survey. Thanks also to the many DMR staff, families, and others for candidly sharing their perspectives on the community training home program and cooperating with the evaluation.